DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00250 (03/2023)

STATE OF WISCONSIN
Wis. Stat. § 49.45(9)
Wis. Admin. Code § DHS 104.03

FORWARDHEALTH

PHARMACY SERVICES LOCK-IN PROGRAM
REQUEST FOR REVIEW OF MEMBER PRESCRIPTION DRUG USE

ForwardHealth requires certain information to process and review information about medical services provided to eligible members.

Members are required to give providers full, correct, and truthful information. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member ID number per Wis. Admin. Code § DHS 104.02(4).

Under Wis. Stat. § 49.45(4), personally identifiable information about applicants and members is confidential and is used for purposes directly related to program administration such as determining the eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement.

The use of this form is voluntary, and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form.

Complete the form and submit it to the Pharmacy Services Lock-In Program by fax at 800-881-5573 or by mail at the following address:

Pharmacy Services Lock-in Program
c/o Kepro
PO Box 3570
Auburn AL 36831-3570

Providers may contact the Pharmacy Services Lock-In Program at 877-719-3123 with questions. Refer to the Medications Monitored by the Pharmacy Services Lock-In Program data table on the Pharmacy Resources page of the ForwardHealth Portal at https://www.forwardhealth.wi.gov/WIPortal/content/provider/medicaid/pharmacy/resources.htm.spage#.

INSTRUCTIONS: Type or print clearly.

SECTION I – MEMBER INFORMATION

Name – Member (Last, First, Middle Initial)

Member ID Number	Date of Birth

SECTION II – REASONS FOR REQUEST TO REVIEW MEMBER'S PRESCRIPTION DRUG USE

Reason (Check the appropriate reason for the referral.)

- ☐ Member uses or is suspected of using multiple pharmacies to obtain restricted medications prescriptions.
- ☐ Member uses or is suspected of using multiple prescribers to obtain restricted medications prescriptions.
- ☐ Member has or is suspected of having multiple prescriptions of the same or similar type of restricted medications substance.
- ☐ Other _____

SECTION III – REQUESTER INFORMATION

Requested by

- ☐ Health Care Provider
- ☐ Pharmacy
- ☐ Caseworker
- ☐ Emergency Room Department
- ☐ Other _____

Name – Requester	Date of Request
Name – Requester's Organization	National Provider Identifier – Requester (Optional)
Phone Number – Requester	Fax Number – Requester

Reset Form